Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $6,204.32 for date of service, 05/25/01.

   b. The request was received on 05/17/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial Submission of TWCC-60
      1. UB-92s
      2. EOB(s)
   b. Additional documentation received on 06/27/02
      1. Position Statement
      2. Medical Records
      3. UB-92
      4. EOBs
      5. EOBs from other carriers
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 07/01/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/02/02. The response from the insurance carrier was received in the Division on 07/29/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/25/02
"…the Carrier did not provide any documentation of a developed or consistently applied methodology, which was used in reducing payment for the treatment/service in question. In addition, the methodology as presented on the explanation of benefits is not representative of a 'fair and reasonable' reimbursement."

2. Respondent: THE RESPONSE WAS NOT TIMELY AND CONSEQUENTLY NOT ELIGIBLE FOR REVIEW.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 05/25/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $7,377.32 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $1,118.00 for services rendered on the date of service in dispute above and denied any additional reimbursement as, "M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE."

5. The amount in dispute is $6,204.32 for services rendered on the date of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The provider has submitted reimbursement data. The provider has submitted EOBs from other carriers. In a review of the EOBs submitted, it is noted that the surgical procedure was the same, but the bills vary in price. For example, the OR charge is as high as $1400.00 and as low as $800.00.

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (I) (1-4) places certain requirements on the Carrier when reducing the billed amount to fair and reasonable. Regardless of the Carrier's methodology or lack thereof, or a timely or untimely response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The carrier has submitted reimbursement data to explain how it arrived at what it considers fair and reasonable reimbursement. Even though the provider has submitted EOBs from other carriers to document what it considers fair and reasonable reimbursement, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. The willingness of some carriers to reimburse at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(b) of the Texas Labor Code. The EOBs provide no evidence of amounts paid on behalf of managed care patients of ASCs or on behalf of other non-workers' compensation patients with an equivalent standard of living. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 14th day of August 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt